

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/29/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAUNALANI NURSING AND REHABILITATION CENTE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5113 MAUNALANI CIRCLE HONOLULU, HI 96816</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 105	<p>11-94.1-22(g) Medical record system</p> <p>(g) All entries in a resident's record shall be:</p> <p>(1) Accurate and complete;</p> <p>(2) Legible and typed or written in black or blue ink;</p> <p>(3) Dated;</p> <p>(4) Authenticated by signature and title of the individual making the entry; and</p> <p>(5) Written completely without the use of abbreviations except for those abbreviations approved by a medical consultant or the medical doctor.</p> <p>This Statute is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure an assessment accurately reflected the resident's status. Resident (R)23 reported having broken, missing, and loose teeth. Review of the resident's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/01/20, Section L. which documents the resident's oral/dental status documented the resident did not have any fragmented and/or broken teeth. As a result of this deficiency, the resident is at risk for potential negative outcomes related to an inaccurate assessment.</p> <p>Findings include:</p> <p>On 10/26/21 at 08:51 AM, during an interview with R23, the resident stated, "I have a lot of teeth in my mouth that are broken or missing and</p>	4 105		

Office of Health Care Assurance  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/29/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAUNALANI NURSING AND REHABILITATION CENTE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5113 MAUNALANI CIRCLE HONOLULU, HI 96816</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 105	Continued From page 1  loose. It is annoying as it causes me to spit a lot." Surveyor's observation of R23 oral cavity confirmed that R23 has broken and missing teeth.  On 10/28/21 at 12:30 PM, a record review was conducted and documented R23's Annual MDS with an ARD of 11/01/20, Section L. documents the resident's oral and dental status. L0200 was coded as "None of the above present" documenting R23 did not have "B...tooth fragment(s)" or "D...broken natural teeth" which contradicted the resident's statement.  On 10/29/2021 at 11:00 AM, conducted an interview with the MDS Coordinator. The MDS Coordinator stated he/she did not complete the Annual MDS with an ARD of 11/01/20 for R23. MDS Coordinator stated the Unit Manager was the person of contact for R23's MDS.  On 10/29/21 at 11:39 AM, conducted a concurrent interview and record review with Unit Manager (UM) 2 at the resident's bedside. UM 2 performed a visual and tactile inspection of R23's oral cavity. UM2 confirmed R23 has broken natural tooth on the lower left side of resident's mouth. UM 2 reviewed R23's annual MDS with an ARD of 11/01/20, Section L Oral/Dental and confirmed it was not accurate for R23.	4 105		
4 136	11-94.1-30 Resident care  The facility shall have written policies and procedures that address all aspects of resident care needs to assist the resident to attain and maintain the highest practicable health and medical status, including but not limited to:	4 136		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/29/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAUNALANI NURSING AND REHABILITATION CENTE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5113 MAUNALANI CIRCLE HONOLULU, HI 96816</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 136	<p>Continued From page 2</p> <p>(1) Respiratory care including ventilator use; (2) Dialysis; (3) Skin care and prevention of skin breakdown; (4) Nutrition and hydration; (5) Fall prevention; (6) Use of restraints; (7) Communication; and (8) Care that addresses appropriate growth and development when the facility provides care to infants, children, and youth.</p> <p>This Statute is not met as evidenced by: Based on interviews and record reviews, the facility failed to provide the necessary care for R7's retention of excess fluids and proper care of his hemodialysis catheter by not utilizing open communication with the dialysis facility personnel and by not having appropriate policy and procedures in place. These deficient practices is a neglect of the specialized needs and care of residents requiring dialysis to live.</p> <p>Findings include:</p> <p>On 10/28/21 at 2:20 PM, R7 was interviewed in the unit's dining room. Informed R7 that surveyor made multiple attempts to see him on 10/26/21 and 10/27/21. R7 stated that he was not in the facility on 10/26/21 because he had an "extra treatment" at dialysis to remove excess fluid and again on 10/27/21 for his regular three times a week hemodialysis session. R7 sat in his wheelchair during the interview and the skin on his lower legs appeared shiny, taut, and darkened in color. He occasionally needed to catch his breath during the interview. He stated that he doesn't drink much and doesn't know how he had gained a lot of fluid. Surveyor noted a white adherent dressing to R7's right upper chest. He</p>	4 136		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/29/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAUNALANI NURSING AND REHABILITATION CENTE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5113 MAUNALANI CIRCLE HONOLULU, HI 96816</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 136	<p>Continued From page 3</p> <p>stated that he has a permanent dialysis catheter to his right upper chest because of difficulties in creating a permanent dialysis access in his arms. R7 states that he is able to shower, but the dialysis catheter dressing needs to be covered with plastic to ensure that it does not become wet. He stated that it became wet after a shower once and the staff used a blow dryer to dry off the dressing. R7 was asked if the staff called the dialysis center to ask what to do with a wet catheter dressing, but he stated that the dialysis facility was not contacted and staff continued to blow dry the dressing until it became dry.</p> <p>On 10/29/21 at 08:16 AM, R7's EHR was reviewed. His weight on 09/02/21 was 178.6 pounds and on 10/08/21 it was 185.6 pounds. "Nutritional/Dietary Notes" dated 10/03/21 and timed 19:39 (7:39 PM), revealed that R7's preferred weight is 180 pounds and he agreed to change his weight goal to be between 175 and 185 pounds.</p> <p>"Nutritional/Dietary Notes" written on 10/27/21 at 10:49 AM, stated " ...weight fluctuations d/t (due to) frequent excess fluids and hx (history) noncompliance with diet, resident is aware of diet restrictions and has received multiple nutrition education re: complying with diet ...Will refer to RD (registered dietitian) to review."</p> <p>R7's care plan did not address R7's needed care and interventions for his increased fluid gain, other than education, which was not effective, causing R7 to need an extra dialysis treatment to remove excess fluids. R7's care plan also stated "Staff may cover the permacath (permanent dialysis catheter) site on right chest with plastic prior to shower. Keep area dry at all times." It did not address the intervention(s) to take if R7's dialysis catheter dressing becomes accidentally wet with his shower. R7's care plan also stated,</p>	4 136		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/29/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAUNALANI NURSING AND REHABILITATION CENTE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5113 MAUNALANI CIRCLE HONOLULU, HI 96816</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 136	Continued From page 4  "May contact (outpatient dialysis center and phone number) for dialysis related concern."  On 10/29/21 at 08:00 AM, a request for the facility's dialysis catheter dressing policy and procedure (P&P) was made to the DON.  On 10/29/21 at 09:31 AM, paper copies of R7's dialysis communication records were reviewed. A handwritten communication to the facility on 10/13/21 from the hemodialysis (HD) nurse stated, "Pls. reinforce fluid restrictions, Pt. (patient) is coming in > (greater than) 5 (five) kg (kilograms) wt. (weight) gain" (equaling to 11 pounds).  On 10/29/21 at 09:47 AM, RN9 was queried about the process the facility uses if a permanent dialysis catheter dressing becomes wet and he stated that he would need to look at the facility's policy.  On 10/29/21 at 11:17 AM, the registered dietitian (RD) was interviewed via telephone. His management of a dialysis resident who has trouble maintaining their fluid restriction is to educate them and he consults with the dietitian at the dialysis facility only if there any concerns with the resident's lab results.  On 10/29/21 at 1:42 PM, a follow up query was made with the ADON and she was asked about the dialysis catheter dressing policy and procedure. She stated that it mentioned only to keep the dressing dry. A copy of the policy and procedure was not given to the surveyor.	4 136		
4 145	11-94.1-38(a) Activities	4 145		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/29/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAUNALANI NURSING AND REHABILITATION CENTE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5113 MAUNALANI CIRCLE HONOLULU, HI 96816</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 145	<p>Continued From page 5</p> <p>(a) The facility must provide for an ongoing program of age-appropriate activities designed to meet the interests, physical, mental, and psychosocial well-being of each resident.</p> <p>This Statute is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide an ongoing program to support residents in their choice and preferences of activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of 1 resident out of 6 in the sample.</p> <p>Findings include:</p> <p>Record review on 10/27/21 at 09:00 AM, documented a 99-year-old alert male was admitted on 08/23/21 for status post fall with left humerus fracture (without surgery).</p> <p>Observation was made on 10/27/21 at 09:23 AM of resident (R)45. R45 would not wake up to his name. At 11:00 AM, R45 sleeping and still in bed.</p> <p>Interview with clinical nurse's aide (CNA)2 who stated, "he is always like that."</p> <p>Record review (RR) on 10/27/21, documented no activity was recorded for R45 on 10/27/21 in the electronic medical record under tasks.</p> <p>On 10/28/21 at 08:15, R45 was sleeping and would not get up. At 08:50 AM, the resident was sleeping and remained in bed for the morning.</p> <p>Interview with Director of Community life (DCL) was done on 10/28/21 at 12:30 PM. DCL explained that our goal for activities is that the</p>	4 145		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/29/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAUNALANI NURSING AND REHABILITATION CENTE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5113 MAUNALANI CIRCLE HONOLULU, HI 96816</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 145	Continued From page 6  residents are out of their room. The CNAs on the floor engage them in activities. It could be something small like watching TV or getting the newspaper. Whomever does not come out of their rooms or engage in activities, we will go do visits in the room. DCL stated this is documented in the chart under tasks.  Observation on 10/28/21 at 12:57 PM of R45 reveals resident sleeping in bed, laying down and TV on.  RR showed no activity was recorded for R45 on 10/28/21 in the electronic medical record under tasks.  Observation of R45 on 10/29/21 with CNA3 was done on 10/29/21 at 8:45 AM. R45 was awake and being assisted with his breakfast meal in bed. Queried CNA3 why R45 has not been out of bed this week. CNA3 was not able to give a definite answer.  RR on 10/29/21 Record did not show any activity for the month of October except on 10/29/21 where group activities was checked off for 12:06 PM under the tasks bar. R45 is care-planned for activity interests and preferences such as playing word games such as scrabble on the phone, joining Veteran's Programs and Events if invited, reading sports news on magazines and the newspaper if offered to me. These activities were not witnessed during this survey.	4 145		
4 159	11-94.1-41(a) Storage and handling of food  (a) All food shall be procured, stored, prepared, distributed, and served under sanitary conditions.	4 159		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/29/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAUNALANI NURSING AND REHABILITATION CENTE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5113 MAUNALANI CIRCLE HONOLULU, HI 96816</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 159	<p>Continued From page 7</p> <p>(1) Dry or staple food items shall be stored above the floor in a ventilated room not subject to seepage or wastewater backflow, or contamination by condensation, leakages, rodents, or vermin; and</p> <p>(2) Perishable foods shall be stored at the proper temperatures to conserve nutritive value and prevent spoilage.</p> <p>This Statute is not met as evidenced by: Based on observation, interviews and record review, the facility failed to prepare, distribute, and serve food in accordance with professional standards for food service safety during dining service.</p> <p>Findings include: On 10/26/21 at 11:41 AM, the dining cart arrived and was parked on the third floor. Meals were prepped by all staff at the nursing station and then brought to residents' rooms. Observation to Room 318 by staff carrying the tray from nursing station without hand sanitization going in. Delivery to Room 316 without hand sanitization coming out of room. At 11:51 AM on 10/20/21, another staff went into deliver a tray to 318 without hand sanitization (HS) going in and no HS coming out. Tray delivery to Room 301 showed no HS going in and no HS coming out of Room 301.</p> <p>Interview with Registered Nurse (RN)1 who stated she was the charge nurse was done. RN1 stated that the protocol is to HS before going in because you have been touching a lot of stuff, after patient care and in between.</p> <p>Further observation done on 10/28/21 at 12:17</p>	4 159		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/29/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAUNALANI NURSING AND REHABILITATION CENTE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5113 MAUNALANI CIRCLE HONOLULU, HI 96816</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 159	Continued From page 8  PM where surveyor observed Unit manager (UM)1 and Certified Nurse Aide (CNA)4 passing trays with no HS before going into the room.  Record Review on 10/28/21 at 02:00 PM of Policy No. N-62 Handwashing/Sanitizing, page 7 "when to sanitize hands" states that staff should sanitize hands " 1) Before entering and upon leaving residents rooms. 2) Before and after handling food.	4 159		
4 203	11-94.1-53(a) Infection control  (a) There shall be appropriate policies and procedures written and implemented for the prevention and control of infectious diseases that shall be in compliance with all applicable laws of the State and rules of the department relating to infectious diseases and infectious waste.  This Statute is not met as evidenced by: Based on observation, interviews and record review, the facility failed to prepare, distribute, and serve food in accordance with professional standards for food service safety during dining service.  Findings include:  On 10/26/21 at 11:41 AM, the dining cart arrived and was parked on the third floor. Meals were prepped by all staff at the nursing station and then brought to residents' rooms. Observation to Room 318 by staff carrying the tray from nursing station without hand sanitization going in. Delivery to Room 316 without hand sanitization	4 203		

Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>125013</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>10/29/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>MAUNALANI NURSING AND REHABILITATION CENTE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5113 MAUNALANI CIRCLE HONOLULU, HI 96816</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 203	<p>Continued From page 9</p> <p>coming out of room. At 11:51 AM on 10/20/21, another staff went into deliver a tray to 318 without hand sanitization (HS) going in and no HS coming out. Tray delivery to Room 301 showed no HS going in and no HS coming out of Room 301.</p> <p>Interview with Registered Nurse (RN)1 who stated she was the charge nurse was done. RN1 stated that the protocol is to HS before going in because you have been touching a lot of stuff, after patient care and in between.</p> <p>Further observation done on 10/28/21 at 12:17 PM where surveyor observed Unit manager (UM)1 and Certified Nurse Aide (CNA)4 passing trays with no HS before going into the room.</p> <p>Record Review on 10/28/21 at 02:00 PM of Policy No. N-62 Handwashing/Sanitizing, page 7 "when to sanitize hands" states that staff should sanitize hands "</p> <p>1) Before entering and upon leaving residents rooms.</p> <p>2) Before and after handling food.</p>	4 203		